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This summer, through the Kellogg Institute internship program, I worked for eight weeks in Bududa, Uganda at a clinic run by the Foundation for International Medical Relief of Children (FIMRC). The clinic is a health center level III, which means it has a lab, pharmacy, and a maternal health unit. The clinic operates with an almost entirely Ugandan staff, with the exception of the FIMRC field operations manager, who currently is a 30-year old from Texas who has worked in international development since graduating college. The medical supervisor of the clinic is a physician, but on a day-to-day basis the person in charge is the Ugandan equivalent of a PA, a clinical officer. The clinic operates on a station system: check in, vitals, consultation, pharmacy, check out, and MCH, the maternal unit. On the days I spent in the clinic, I would help with any of the stations, taking vitals, scribing in consultation, record keeping in the pharmacy or lab, or shadowing in MCH. The current FIMRC clinic was built in March of this year, with the addition of MCH being new to this new location. The delivery bed for the maternal unit arrived at the end of June, and at the beginning of July I got to see the first birth at the clinic, a baby boy named Emma.

In addition to the clinic, which sees anywhere between 75 and 150 patients a day, FIMRC has an extensive community outreach program. Community Health Educators (CHEs) regularly do sanitation checks and health education and guardians visit their assigned Orphaned and Vulnerable Children, (OVCs). Interns at the clinic can also go along on outreach with the CHEs.

This summer I worked closely with the HIV consultant. In addition to running the Voluntary Counseling and Testing program at the clinic (VCT), the consultant organizes a

program for HIV positive adults called the Post Test Club (PTC) and a program for HIV positive youth, the Orphans and Vulnerable Children (OVCs).

The OVC program began a new initiative in January where each child planted a garden to provide an extra source of food for themselves. The OVCs are responsible for the care and upkeep of their gardens and most pick food from their gardens daily to supplement their diets. During the first half of my summer I went to each child's garden to check the status of the padlock, fence, the number of plants, which plants needed transplantation, and to spray the gardens with an insecticide. The OVCs come from areas both near and far to the clinic, and I spent a lot of time walking the dirt roads and small trails throughout the Bududa district, with one of the guardians.

During the second half of my summer I went back to each home to do OVC home visits, completed monthly by someone on the FIMRC staff. I interviewed caretakers about hygiene, medicine storage, sanitation, nutrition, social groups, and education of the children. I worked with the staff to develop a new and more comprehensive form to use for visits, and created a scoring system for this form to be able to quantitatively track the progress of the OVCs over time.

From this I learned that the majority of the children attend school only two or three times a week because their families cannot afford the entirety of school fees required. Families pay part of the fee, so their children get to attend school a few days a week, and are sent home the other days. Education in government schools is supposed to be free in Uganda, but teachers still charge these fees in order to generate more income for themselves. Knowing that fundraising for these fees would not be sustainable, nor would the families actually spend the money on the fees, I discussed other ideas with my manager. He said there are thoughts of starting a "garden 2.0"

project, the products of which would be sold to generate money for school fees. This project would require a long term volunteer, though, in order to ensure the consistent progress of the project, especially in the beginning. It was frustrating at first to realize that fundraising in the US could easily raise money for these fees, but that such a solution would not solve the problem long-term. I did learn a lot about thinking more critically about solutions that are based on long-term sustainability and that originate with the families and kids themselves.

Throughout the summer I worked on a camera project with the OVCs. Using two old point and shoot digital cameras from the FIMRC guest house, I gave each child a camera for two or three days to take photos of where they sleep, where their water comes from, what they eat, and where they keep their medicines. Through this participatory research, the children would get to have a more active role in assessing their own well being, and the photos would give the most accurate information about living conditions.

What I learned from my camera project was that a large number of the 23 OVCs sleep without mosquito nets, and many of the ones that do sleep in nets with holes. Because of this, four of the OVCs had malaria just in the last month.

In addition to my work with the OVCs, I worked with the PTC program developing a curriculum of health education about non-communicable diseases. For a three week series on hypertension, diabetes, and cancer, I created PowerPoint presentations and rice sack lessons to not only be presented while I was there, but to be used continuously in the future, both for the PTC and other groups.

Because noncommunicable diseases, especially high blood pressure and diabetes, are caused in large part by unhealthy lifestyles, I had to adjust the way I approached the issue in the rural setting of Bududa. Talking about “exercise” and an “active lifestyle,” takes on a different

meaning when most people dig all day in the garden for a living. The idea of “fitness” isn’t really a common one, so we discussed not remaining sedentary for long periods of time, making clear that digging is an acceptable way of doing that. Further, “balanced diet” means something different when most of the food people consume is just based on what they grow. The word “food” even means something different—used to describe the main starches people consume (posho, matoke or rice), not everything people eat. The main dietary issues of those in Bududa are consuming too much sugar with tea, and cooking with too much oil and salt. Once we discovered this, it became the focus of our nutritional advice.

Throughout my summer, I was challenged and humbled as I worked in an environment completely foreign to me. I learned a lot about public health and international development, but also more than I could have imagined about developing projects, taking initiative, speaking a new language, bridging cultural barriers, becoming comfortable being uncomfortable, how politics and history influence the people of a country, how to navigate new cities, and how to work with people who have vastly different backgrounds than my own. While I feel my work with the OVC and PTC programs had positive impact on FIMRC, and my experience will lead to my continued involvement with the organization, what I got out of the summer cannot really be quantified. It was difficult in ways I could never have been challenged in the United States. Working through the daily struggles that come with living in rural Uganda and coming to terms with the suffering that pervaded my summer in ways obvious and hidden has left me with new ideas of how I want to affect change through my career. It is impossible to fully prepare for the kinds of questions that working in a developing country will leave you with, but the opportunity to have experiences that force me to begin to ask those questions is one I am grateful I had.